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Mr. Baum

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NATIONAL ADVISORY COUNCIL ON REGIONAL MEDICAL PROGRAMS

Rockville, Maryland

Wednesday, 7 February 1973

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DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Public Health Service

Health Services and Mental Health Administration

NATIONAL ADVISORY COUNCIL ON REGIONAL MEDICAL PROGRAMS

Conference Room G-H
Parklawn Building
Rockville, Maryland

Wednesday, February 7, 1972

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P R O C E E D I N G S

DR. MARGULIES: May we please bring the meeting to order.

I have just a few announcements to make before we begin this session of the National Advisory Council, the first portion of which is, as you know, open to the public. There is within your agenda book the usual material on the confidentiality of the closed portion of the meeting. This particular portion of the meeting is, however, open to the public and will remain open until an announcement is made of the portion which is closed for review of applications.

Today, Dr. Musser is being represented for the Veterans Administration by Dr. Paul Haber, who is over on the right. Mr. Ogden cannot attend, nor can Dr. Roth, because of illness in his family, and I'm not sure at what point either Dr. Stone, who is acting deputy administrator, or Dr. Sencer, acting administrator of HSMHA, will be present, but we will adjust according to their time of arrival.

We already know of a number of people who are here representing public interest in the meeting and they will be given an opportunity to participate in the discussion within a relatively short period of time; in fact, as soon as we get into the agenda material on any of the items which come up.

We will also, for their convenience and that of the Council, if it appears to be the best thing to do as the

1 discussion flows, set aside a time for them in which they can
2 say whatever they wish to say because I know a number of them
3 have prepared statements which they wish to make.

4 I would also like to introduce to you, if you
5 haven't already met him, Dr. Paul Teschan, who is sitting right
6 there facing me. He's the coordinator of the Tennessee Mid-South
7 program and he's attending the meeting in his capacity as
8 chairman of the steering committee of the regional medical
9 program coordinators.

10 Now, if there is anyone here who represents an
11 organization or himself of public interest who we don't know
12 about, please let your presence be known to either Ken Baum,
13 who's here, or Miss Handal, who's over there at the desk, and
14 we will make sure that there's room for you to discuss whatever
15 you wish to discuss. Any presentations which are made by the
16 public can be read into the record. They should be limited to
17 about five minutes of time as a maximum, and there is a floor
18 microphone as you can see at the far end for any kind of dis-
19 cussion which may be required.

20 As I said a moment ago, we would expect Dr. Stone
21 to come here at some time and here he is. Good morning, Fred.
22 Glad to see you.

23 I would like to read to you a letter which Dr.
24 Wilson prepared before he left which is as follows:

"Ladies and gentlemen:

1 "By the time this reaches you I will have already
2 left the position of administrator of Health Services and
3 Mental Health Administration to return to the University of
4 Missouri. I feel I would be remiss if I did not express my
5 sincere sense of gratitude for the considerable advice and
6 counsel you have provided to me and to HSMHA during my incum-
7 bency. Please accept my thanks and most sincere wishes for
8 the successful pursuit of your personal goals. I hope we will
9 meet many times in the future in our joint efforts to improve
10 the health care of the people of our country." Signed, "Vern
11 Wilson."

12 I think that you may recall from the last meeting
13 of the Council that we did announce to you the fact that the
14 RMP was to receive the Health Advancement Award from the
15 National Kidney Foundation and that event in fact did occur
16 shortly after the last meeting of the Council. It was dis-
17 cussed, but I suppose you might enjoy some concrete evidence
18 of the fact that it did occur, so I will pass this around and
19 you can admire it and make sure you return it to the head of
20 the table so we can hang it back up on the wall. Hereafter,
21 if you want to look at it, I will tell you where the wall is
22 located.

23 There are a few vacancies on the Council which
24 have not been filled and there are some people who, as you may
25 recall, have completed their terms of service on the Council;

1 and by the rules of appointment will no longer serve. These
2 include: Dr. DeBakey and Dr. Milliken; Harold Hines who
3 resigned due to conflict of other kinds of demands on his time;
4 Dr. Brennan, Dr. Komaroff, and Mrs. Weikoff and Mrs. Curry.
5 Now, some of those may be reappointed based upon the time for
6 reappointment and some of the technicalities of Council appoint-
7 ments, but for the time being they are not members of the
8 Council for this particular session. Some of them, as I indi-
9 cated, have served out their full period of time.

10 We have had a discussion at the last meeting of the
11 reasonable time for another meeting within this fiscal year.
12 We had set the dates of June 5 and 6, which we would like to
13 continue to keep as the dates of the next meeting of the
14 Council, if there are no serious objection to it.

15 DR. OCHSNER: I can't be here on the 5th.

16 MRS. MARS: I can't be here on either the 5th or
17 6th. The American Cancer Society has its annual meeting then.

18 DR. MARGULIES: That's two people. Are there any
19 other objections to those dates?

20 DR. MEYER: Monday and Tuesday would be better.

21 DR. MARGULIES: Would Monday and Tuesday be
22 acceptable?

23 DR. SCHREINER: I can't be here then.

24 MRS. MARS: How about the week before or the week
25 after?

1 DR. MARGULIES: The week after gets to be extremely
2 difficult. It's pretty late in the fiscal year.

3 MRS. MARS: How about the week before?

4 DR. MARGULIES: The problem there is if we continue
5 as we have been we have foreshortened the time between review
6 and Council by too short a time. Would the 4th and 5th be
7 acceptable to people?

8 DR. SCHREINER: I can make it the 5th but not the
9 4th.

10 DR. MARGULIES: How about the 7th and 8th?

11 DR. SCHREINER: How about the 6th and 7th?

12 DR. MARGULIES: Let's have a vote on the 6th and
13 7th. (Show of hands) How about the 7th and 8th? Well, it
14 looks like 6th and 7th is all right.

15 You have had a copy of the minutes of the last
16 meeting of the Council and had an opportunity to review them.
17 I'll be glad to receive any comments on it for corrections or
18 a vote for their acceptance as mailed.

19 MRS. MORGAN: I move we accept the minutes as
20 mailed.

21 DR. SCHREINER: Second.

22 DR. MARGULIES: It's been moved and seconded that
23 we accept the minutes as mailed to the members of the Council.
24 All in favor, say "Aye."

("Ayes")

1 DR. MARGULIES: Opposed?

2 (No Response)

3 DR. MARGULIES: I would like to report to you and
4 have any members of the Council who wish to add their comments
5 and those who are present on the meeting we had on the quality
6 of care which took place last month in St. Louis.

7 We had, for well over a year, planned to have a
8 conference on all of the issues involved in quality assessment
9 and assurance. This was discussed in prior sessions of this
10 Council and it was presented in what detail was available when
11 we met last time for the formal meeting of the Council.

12 That meeting did take place in January. It was, I
13 think, a remarkably successful meeting. It consisted of a
14 cross-section of remarkably competent speakers presenting
15 papers addressing the whole range of issues with which one is
16 concerned in measuring and maintaining the quality of care. It
17 was designed in such a way that each speaker was limited to
18 20 minutes. There were a total of 28 speakers. They stayed
19 on schedule. We had asked that people come with papers pre-
20 pared, written, and ready to be published. They all did. The
21 only exception was the one who had to summarize the conference
22 and therefore couldn't have a prepared paper.

23 We promised that they would be ready for printing,
24 publication and circulation within 30 days after the conference
25 was completed and that will be done. So that what will emanate

1 from this will be the best single collection of material on
2 the subject of quality assessment and assurance that's available
3 anywhere.

4 DR. SCHREINER: Will we automatically get a copy
5 of that?

6 DR. MARGULIES: All members of the Council and
7 members of the Review Committee will. We have prepared the
8 first time around a fairly large printing and we anticipate
9 having to increase that printing considerably because there's
10 already a very heavy demand for it.

11 The format was such that it at least covers most
12 of the fundamental issues and presents a very good sampling
13 of the active work which is going on in everything from the
14 development of effective medical records to the measuring of
15 outcome of health care delivery systems.

16 Now, we did limit attendance to regional medical
17 programs because we wanted to keep the activities on schedule.
18 We felt that by early circulation and publication of the papers
19 we would serve a much large audience much faster than we would
20 have had we had a very large attendance and a lot of discussion.
21 So far as I can tell, it worked out quite effectively.

22 I would, however, appreciate any comments which
23 members of this Council might wish to make, those who were
24 present. Mrs. Mars was there, Dr. Watkins, Al McPhedran and
25 Mrs. Morgan. I would appreciate any comments you would like

1 MRS. MARS: I think it was very constructive
2 thinking presented but I wish we might have come to more con-
3 clusions, more solutions, let's say, rather than conclusions.
4 But certainly, it was a comprehensive coverage of the picture
5 and all different aspects were presented, but no definite
6 solutions reached, and I think we're floundering and floundering
7 around here trying to find solutions which are very difficult
8 to reach, but certainly it gave everyone food for thought.

9 MR. WATKINS: Are you going to send these to all
10 departments of health?

11 DR. MARGULIES: Yes. We have a mailing list. We
12 would be glad to get any further suggestions from members of
13 the Council or others as to what the mailing list should be,
14 but we anticipate certainly sending them to all the regional
15 medical programs, to state health departments, to state medical
16 societies, medical school libraries, etc.

17 MR. WATKINS: Can I give a name to someone here?

18 DR. MARGULIES: Sure. Do either of you have any
19 further comment?

20 MRS. MORGAN: No.

21 DR. MARGULIES: Paul, would you like to comment?

22 DR. TESCHAN: I'm interested in the comment about
23 the diffusion of efforts and, as you say, floundering in the
24 various presentations. I think our reaction to that is that
25 the conference clearly represented the state of the art today

1 and it clearly represented the kinds of efforts that are being
2 made by people who are trying to find out how to do it. To
3 me, this is the exciting feature because we still have that
4 kind of pluralism, that kind of adventure, to see how we can
5 do it better.

6 I hope that however things go in this entire
7 standard setting, data base gathering, and medical audit
8 arranging, we will be able to build on these various experi-
9 ments and find new ones, find others, and that we don't make
10 an early casting in bronze of any particular method.

11 So I think the idea of having a wide range of
12 choices is exactly the message that came through to the
13 coordinators and it stimulated the efforts in quality assurance
14 across the country and it's a very interesting kind of reaction
15 because you can see that this is a new field and really one
16 that, for the first time, gives us a very sharp target for the
17 educational efforts of RMP. To me, this is really where it
18 comes home.

19 DR. MARGULIES: This leads in rather naturally to
20 where things stand in a very broad way on the PSRO activities
21 within the department. That, to those of you who haven't been
22 following it closely, is the activity which was initiated under
23 new legislation passed late during the last session of Congress
24 which will establish a method of review of the quality of care
25 which is provided and which will be associated with reimbursement

1 under Medicare and Medicaid. There is at the present time a
2 fairly wide range of developmental activities going on in the
3 department but so far as I can tell, no highly specific assign-
4 ment of responsibilities. I'm sure as soon as the Secretary
5 is confirmed and other positions are filled within the depart-
6 ment, these will become more definite.

7 What we have done in HSMHA is what I think is a
8 reasonable kind of thing, and that is to work together across
9 programs within the agency to gain as effective an understanding
10 as we can of many of the issues that will arise with the
11 development of PSRO organizations, taking a look at some of
12 the problems of data gathering, of the establishment of
13 criteria, the general management of the PSRO structure.

14 This is being done not with any specific concept
15 of a final action or responsibility within the agency but,
16 rather, through a sense of professional needs to be prepared
17 to respond to whatever is asked of the agency as PSRO activi-
18 ties are being developed.

19 There is required under law the establishment of
20 a director for the program. He's not yet been named, and a
21 national council to advise the PSRO activity and, of course,
22 that council is yet to be named.

23 But it has created a wide flurry of interest
24 within this agency, certainly within the Social Security
25 Administration, and throughout the country. We deliberately,

1 in the conference in St. Louis, avoided the subject of PSRO
2 because it would have trapped us into talking a lot about
3 administrative problems and about some of the emotional issues
4 which arise when we discuss PSRO and we were primarily con-
5 cerned in looking at the subject of quality assessment and
6 assurance, regardless of what setting it was placed in; and as
7 a consequence, I think we were able to make better progress
8 than we otherwise would.

9 Any questions or comments on this?

10 MR. WATKINS: Are the various disciplines expected
11 to be represented on this PSRO?

12 DR. MARGULIES: I think the PSRO council is des-
13 cribed within the legislation and, as I recall, that council
14 is made up entirely of physicians. Now, I could be corrected
15 on that.

16 MR. WATKINS: That's how it's listed, medical
17 societies and physicians. What I'm asking is that --

18 DR. MARGULIES: Are you talking about the national
19 council or the local PSRO?

20 MR. WATKINS: Local.

21 DR. MARGULIES: I think the local PSROs are
22 expected to be made up of a fairly broad spectrum of the health
23 providers. During the phases of its development -- that is,
24 when the Bennett amendment was being debated -- the congressional
25 intent was quite clear that this would provide an opportunity

1 for a very wide representation of the providers of medical
2 care and it was also quite clear that it could not be the
3 captive of any one segment of the health professional community.
4 So even now, some of the foundations which have been esta-
5 blished and which anticipate becoming PSROs have decided that
6 they have to broaden their structure to make sure that they
7 include some providers of medical care who have not been on
8 their governing boards who need to be if this is to be a PSRO
9 as they anticipate is required.

10 I think you might be interested at this point in
11 the proceedings with a discussion of the President's budget
12 message and the effect which this has on the Regional Medical
13 Programs, and I assume that this is one of the things which
14 has stimulated people to come to make some statement about
15 the Regional Medical Programs.

16 If you have followed that budget, you know that it
17 was one which was marked by austerity, which was designed
18 around a very clear determination to keep government expendi-
19 tures under control in this fiscal year and in the subsequent
20 fiscal year, and has, as a consequence, gone through the entire
21 panoply of government supported operations and reduced or
22 eliminated whatever it felt could be reduced or eliminated
23 with the maintenance of an effective federal activity and
24 still with a consistent operation which will prevent inflation
25 and uncontrollable or undesirable expenditures.

1 Certainly, a number of the decisions which were
2 made have already been widely discussed. The actions on
3 Regional Medical Programs are clearcut and we are taking
4 appropriate steps to carry out those actions.

5 Let me go back over the situation as it was prior
6 to the deliverance of the President's message on the budget.
7 We operated during the entire fiscal year under what is known
8 as a continuing resolution. That is a legislative arrangement
9 which allows programs for which funds have not been appro-
10 priated to continue to operate until those funds have been
11 appropriated. We won't go back over the rules of how that
12 functions.

13 There were on two occasions appropriation acts
14 reported out by Congress which were vetoed by the President
15 because they represented, in his judgment, excessive spending.
16 As a consequence, we were on a continuing resolution and
17 technically still are until February 28, until Congress acted
18 further or until the President's budget message was presented.

19 When it was presented, it represented two fiscal
20 years so far as health activities are concerned, the remainder
21 of this fiscal year and next fiscal year. The initial recommen-
22 dation at the beginning of the fiscal year by the President
23 for Regional Medical Programs was a total of about \$125 million.
24 With the amendments, two things occurred which led to the con-
25 clusion that the Regional Medical Programs will be phased out.

1 In this fiscal year, the total amount available for grants is
2 approximately \$55 million and there will be no funds available
3 for Regional Medical Programs under Title 9 for fiscal year
4 1974.

5 Now, this is possible and logical because the
6 legislation for Regional Medical Programs terminates on
7 June 30 of this year. The Administration will not submit new
8 legislation for continuation of RMP. Consequently, those
9 operations which must be maintained after June 30 will be
10 supported by funds which are placed under Section 304, which
11 is in the National Center for Health Services R&D, so that
12 the operational activities of RMP will be maintained in the
13 next fiscal year as necessary during the phase-out processes
14 of RMP and there will be no funds which will be appropriated
15 for Regional Medical Programs in fiscal year 1974.

16 Now, this means that we had to take certain steps
17 in order to go from where we are to where it is intended that
18 we need to go. After it became clear what the message was and
19 what the plans were, we sent out, with the approval of the
20 Health Services and Mental Health Administration administration,
21 a telegram, a copy of which you were also sent---I don't know
22 whether they got to you in time or not -- which provides a
23 series of steps for the RMPs in deciding what it is they pro-
24 pose to do to move from where they are to a termination of
25 activities by a specific date.

1 Now, our primary goal is to reduce RMP activities
2 from where they are to a point of phase-out as close to June 30
3 as possible of this current year. We have provided oppor-
4 tunities, however, for an orderly and an equitable phase-out
5 because there are obviously some potential disparities based
6 upon our method of providing grants and on the accidents of the
7 past year.

8 You may recall that what has happened in the grant
9 process is as follows: We have Regional Medical Programs now
10 operating on three different fiscal years. One begins in
11 September; one begins in January; and one begins in May of each
12 year. It's the latter group that we are here to review during
13 the closed session of this Council. Those that were reviewed
14 for September were given a grant award for the following year,
15 for a full year. Those that were reviewed for January were
16 affected by the new budget message or in anticipation of the
17 new budget message and were given grant awards to cover six
18 months of operation, taking them from January 1 to June 30,
19 and those which will be reviewed this time will have grant
20 awards only for the remaining two months of our fiscal year in
21 which they are operating, which means that there will be
22 clearcut disparities in the funds available under these arrange-
23 ments.

24 As a consequence, what we plan to do is ask all
25 programs to come in by March 15 with a description of how they

1 propose to phase out their activities and we will look at the
2 total of the sums available in this fiscal year from this
3 fiscal year, distributed unevenly at the present time, and try
4 to carry out some kind of distribution which leads to an
5 equalization of the opportunities they have to phase out their
6 activities in an orderly fashion.

7 Now, I don't know whether you have had an oppor-
8 tunity to review this telegram, but if there are any questions
9 about that or about this process of phase-out at the present
10 time, I will be glad to answer them and Dr. Stone, if he cares
11 to, can add anything that I'm unaware of.

12 DR. MERRILL: In reading the telegram and thinkin
13 about one or two of the grants which I was asked to review, it
14 seemed to me there was no possibility that such a grant, if
15 approved, could be funded since it could not be started before
16 June '73. Is that correct?

17 DR. MARGULIES: Yes. One of the things which we
18 obviously had to include in our requirement was that there
19 could be no new starts at the present time. So what we really
20 will be talking about -- and we have some ideas we'd like to
21 discuss with you in the closed meeting about the present
22 review -- what we will be talking about is a way of phasing out
23 or of doing some rebudgeting for an orderly phase-out, not any
24 new starts at all.

1 to handle contracts which have finite lengths.

2 DR. MARGULIES: Contracts, where there is a clear-
3 cut commitment, will require some special consideration. Cer-
4 tainly, those which were funded out of fiscal '72 funds and
5 which are contracted to carry out their activities over a
6 finite period of time will have a level of protection which is
7 different from grant activities. Those which have been ini-
8 tiated in fiscal '73 will be looked at as contracts which
9 should be allowed to continue if the total amount of funds
10 available for orderly phase-out will allow it, but there may
11 have to be, as we finally get to the point of total funds
12 available in the fiscal year, some reassessment of that as well.
13 We would hope not, but it would be difficult to tell until we
14 see what the response is on March 15.

15 Now, if the Council would like to wait for a
16 moment for any further comments or questions, I do think that
17 if there are members of the public who would like to comment
18 at this time it would be highly appropriate. I will do this
19 in the order in which I just happen to have the names written
20 down here unless someone has a reason to come in some other
21 order I'll be glad to have them do it. We would like to have
22 you indicate if you represent an organization, what organization
23 it is, and if you wish to leave something for the record we
24 will be glad to include it in the record of the Council pro-
25 ceedings.

1 The first name I have is Dr. Frederic Burke.

2 DR. BURKE: Dr. Margulies and distinguished members
3 of the National Advisory Council of the Regional Medical
4 Program, I appreciate this opportunity to submit a brief
5 statement in support of continued assistance to develop and
6 maintain programs for children with chronic lung diseases. I
7 have just a one-page statement to make and some appended
8 material summarizing the essential thrust and mission of our
9 efforts in pediatric pulmonary disease which I will leave for
10 your perusal.

11 My name is Dr. Frederic G. Burke and I am professor
12 of pediatrics at Georgetown University and Vice President of
13 the Association of Pediatric Pulmonary Centers. I represent
14 all the pediatricians of the country and all of the staffs
15 of these Pediatric Pulmonary Centers. The National Tuberculosis
16 and Respiratory Disease Association is fully in accord with
17 the objectives of these centers and has in the past supported
18 these objectives aided by the Regional Medical Program.

19 We are deeply concerned about reports indicating
20 deep financial reductions and indeed elimination of the
21 services offered by the Regional Medical Program. Approxi-
22 mately 32 Pediatric Pulmonary Centers, proposed or existing,
23 are threatened to be aborted or eliminated by such a step.
24 Twelve of these centers are currently supported by RMPS.

 Representing over seven million children afflicted

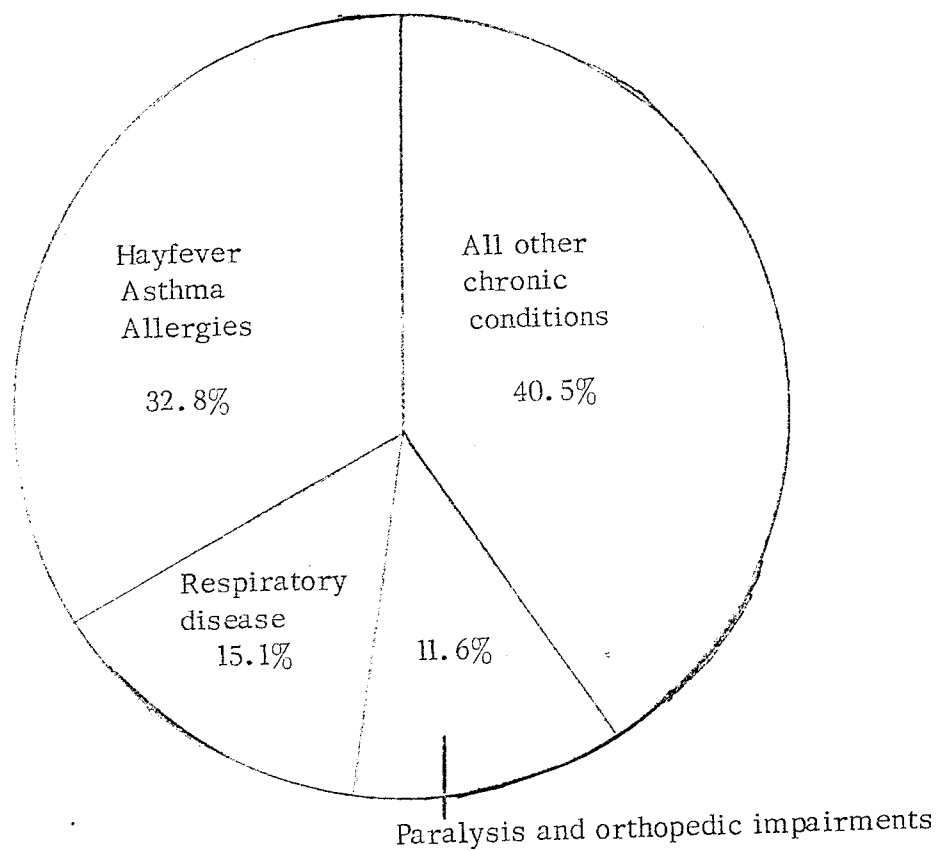
1 with lung diseases, I would like to plead most strongly for
2 them and urge continued financial support to the splendid
3 network of pulmonary centers intitiated by the Regional Medical
4 Program Services. A listing of these centers and a map indi-
5 cating their geographical and regional distribution is appended
6 to this statement.

7 The Pediatric Pulmonary Centers provide care for
8 children and young adults afflicted with lung disease. We
9 believe that much of the high incidence of chronic lung
10 disease in adults has its beginnings in early life and by early
11 diagnosis and proper treatment in this period, much of the
12 tragic consequences of pulmonary crippling can be reduced.
13 These centers tress preventive services, improved clinical
14 diagnosis and management. They are also committed to the
15 education of professionals and the training of paraprofessionals
16 in the care of children and young adults with chronic lung
17 diseases. Figures documenting the scope and importance of
18 these diseases in our young population are also appended. It
19 is precisely because of these figures that programs for the
20 care of individuals with chronic lung disease have consistently
21 received high rankings in the priorities established locally
22 by the Regional Medical Programs.

23 The needs of these seven million children and their
24 families demand a continuity of support that must not be inter-
25 rupted by political and jurisdictional change.

Incidence and Importance of Recognition of Chronic Pulmonary Disease in Children

Forty-eight percent of all chronic conditions in children under the age of seventeen are due to allergy-respiratory conditions. This is a significant part of pediatric practice, so much so that we believe more emphasis needs to be turned to early recognition and treatment of these problems.



Incidence of Chronic Diseases of Children Under 17 Years of Age

DATA ON CHRONIC PULMONARY DISEASE IN CHILDREN

Source - National Center for Health Statistics - HEW, Washington

Unpublished figures from interview survey of civilian population, non-institutionalized.

1967 - Prevalence of Selected Chronic Pulmonary Disease among Children under 15 years

Hayfever without Asthma	1,934,000
Asthma with or without hayfever	2,840,000
Sinusitis	1,130,000
Bronchitis	1,401,000
Other	723,000
	<u>7,228,000</u> *

Rate per 100 Population

Hayfever without Asthma	3.2%
Asthma with or without hayfever	3.4%
Sinusitis	1.9%
Bronchitis	2.3%
Other	1.2%

* The figure of 5 million children in the U. S. afflicted with chronic pulmonary disease did not include hayfever without asthma.

THE IMPACT OF ACUTE AND CHRONIC ILLNESS
IN RESTRICTING CHILDREN'S ACTIVITIES
(National Health Survey, 1968)

	LIMITED IN SCHOOL OR PLAY FOR ILLNESSES	LIMITED IN SCHOOL (alone) FOR ILLNESSES	DAYS SPENT IN BED FOR ILLNESSES
	(age 0 - 15)		(age 0 - 15)
CHILDREN WITH CHRONIC CONDITIONS (1966-1967)	1,097,000		
PER CENT OF ALL CHILDREN WITH CHRONIC CONDITIONS			
TOTAL DAYS OF RESTRICTED ACTIVITIES FOR <u>ALL</u> CHILDREN (1968)	597,133,000 (almost 10 days lost by every child)		267,655,000 (4.5 days lost by every child)
	(age 0 - 17)	(age 6 - 16)	(age 0 - 17)
DAYS LOST FOR LISTED <u>ACUTE</u> CONDITIONS (1968)	605,629,000	191,562,000	266,973,000
-----	-----	-----	-----
1. Infections	98,020,000	33,209,000	49,561,000
2. Acute Respiratory	343,605,000	122,683,000	169,288,000
a. Acute URI's (colds)	(175,067,000)	(59,005,000)	(73,211,000)
b. Influenza	(143,400,000)	(60,719,000)	(84,996,000)
c. Other Acute Resp.	(20,128,000)	(2,959,000)	(11,080,000)
3. Gastro-Intestinal	25,563,000	7,772,000	10,459,000
4. Injuries	81,130,000	12,035,000	15,383,000
5. All Other Acute	57,261,000	15,373,000	22,277,000
DAYS LOST FOR LISTED <u>CHRONIC</u> CONDITIONS (1968)	62,912,000	27,667,000	11,067,000
-----	-----	-----	-----
1. Asthma (22.3% rate set in 1959-1961)		6,336,000	
2. Other Allergies (4.5%)		1,245,000	
3. Other Respiratory Diseases (27.6%)		7,636,000	
4. All Other Chronic Conditions (45.0%)		12,450,000	
DAYS LOST FOR <u>ACUTE</u> AND <u>CHRONIC</u> CONDITIONS	668,541,000	219,229,000	278,040,000

PREVALENCE OF CHRONIC CONDITIONS AMONG CHILDREN
IN THE UNITED STATES OF AMERICA
(National Health Survey, 1968)

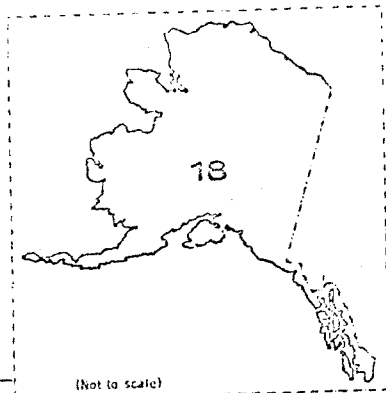
	<u>BOYS</u>		<u>GIRLS</u>		<u>BOTH</u>
TOTAL POPULATION	51.90%	34,776,000	48.10%	32,230,000	67,006,000
ALL CHRONIC LISTED CONDITIONS	25.42%	8,840,000	21.04%	6,780,000	15,620,000
1. Hayfever, Asthma & other allergies*	10.67%	3,711,000	9.02%	2,907,000	6,618,000
2. Other Respiratory Conditions*	5.99%	2,033,000	5.10%	1,644,000	3,727,000
3. Orthopedic & Paralytic	2.48%	862,000	2.20%	709,000	1,571,000
4. Skin Diseases	1.43%	497,000	1.53%	509,000	1,006,000
5. Digestive	1.32%	459,000	0.85%	274,000	733,000
6. Speech Disorders	1.19%	414,000	0.50%	161,000	575,000
7. Hearing Problems	0.96%	334,000	0.63%	203,000	537,000
8. Visual Disorders	0.65%	226,000	0.56%	180,000	406,000
9. Mental & Nervous Conditions	0.73%	254,000	0.60%	193,000	447,000
* ALL CHRONIC RESPIRATORY	16.66%	5,794,000	14.12%	4,551,000	10,345,000 (15.4%)

CHILDREN WHOSE ACTIVITIES ARE RESTRICTED
BY CHRONIC DISEASES

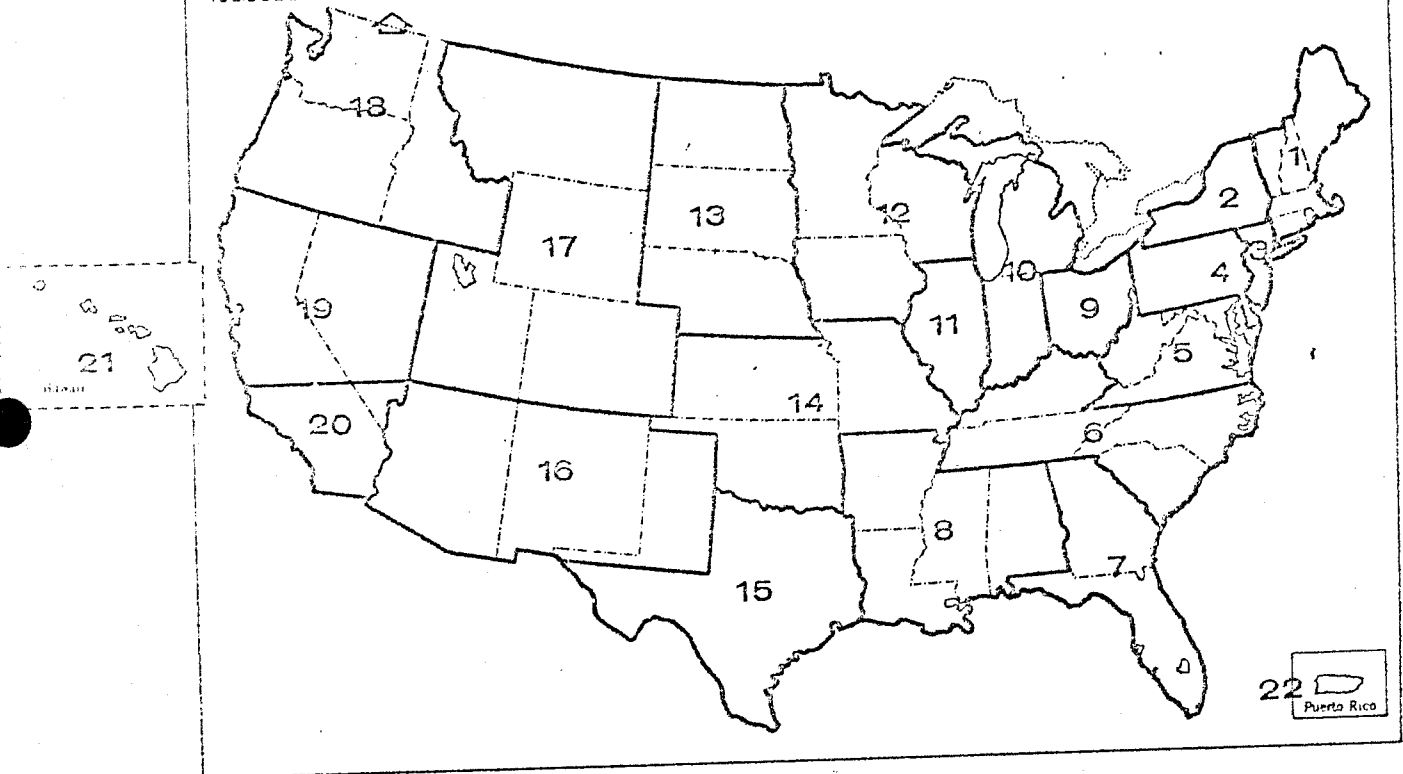
	NUMBER	PER CENT OF ALL CHILDREN	PER CENT OF ALL CHRONIC CONDITIONS
ALL CHRONIC CONDITIONS	15,620,000	23.3%	100.0
THOSE WITH ANY LIMITATIONS	1,427,000	2.1%	9.2%
THOSE WITH SOME LIMITATIONS IN SCHOOL OR PLAY ACTIVITIES	825,000	1.2%	5.3%
THOSE WITH "LEISER" LIMITATIONS	602,000	0.9%	3.9%

(Data from the National Health Survey, 1968)

A PROPOSED PLAN
FOR
REGIONAL PEDIATRIC PULMONARY CENTERS



(Not to scale)



CENTERS CURRENTLY CONSIDERED ACCEPTABLE
FOR CONSIDERATION AS PEDIATRIC PULMONARY CENTERS

No.	Area	Center	Location
1	Northeast	Combined Boston Medical Schools and Boston Children's Hospital	Boston, Mass.
2	Northeast	Yale University	New Haven, Conn.
3	Upper New York	Albany Medical Center	Albany, N. Y.
4	Upper New York	Rochester Medical School	Rochester, N. Y.
5	Metropolitan New York and New Jersey	Combined New York Medical Schools and Babies Hospital	New York, N. Y.
6.	Greater Delaware Valley and Pennsylvania	Combined Philadelphia Medical Schools and Hospitals	Philadelphia, Pa.
7	Washington, D. C. Maryland and the Virginias	Combined Washington, D. C. Medical Schools and Hospitals	Washington, D. C.
8	Mid-Atlantic	Duke University Medical School	Durham, N. C.
9	Southeast	Medical College of Georgia	Augusta, Ga.
10	South	Tulane University Medical School	New Orleans, La.
11	South	University of Mississippi Medical Center	Jackson, Miss.
12	No. Ohio	Case Western Reserve Medical School	Cleveland, Ohio
13	So. Ohio	Ohio State Medical School	Columbus, Ohio
14	Michigan	Detroit Children's Hospital	Detroit, Mich.
15	Indiana	University of Indiana Medical School	Indianapolis, Ind.
16	Illinois	Northwestern University Medical School and Children's Memorial Hospital	Chicago, Ill.
17	Minnesota	University of Minnesota Medical School	Minneapolis, Minn.
18	Wisconsin	University of Wisconsin Medical Center	Madison, Wisc.
19	Plains	University of Nebraska	Omaha, Nebr.

No.	Area	Center	Location
20	Missouri	Combined St. Louis Medical Schools and Hospitals	St. Louis, Mo.
21	Kansas	University of Kansas Medical Center	Kansas City, Kans.
22	Oklahoma	University of Oklahoma Medical School	Oklahoma City, Okla
23	Texas	Baylor Medical School	Houston, Texas
24	Southwest	Lovelace-Bataan Medical Center and The University of New Mexico Medical School	Albuquerque, N.M.
25	Rocky Mountain	University of Colorado Medical School	Denver, Colo.
26	Intermountain	University of Utah Medical School	Salt Lake City, Utah
27	Washington/ Alaska	University of Washington Medical School	Seattle, Wash.
28	Oregon	University of Oregon Medical School	Portland, Ore.
29	No. California/ No. Nevada	Combined Medical Schools and Hospitals, San Francisco and Oakland Bay Area	San Francisco, Cal
30	So. California/ So. Nevada	Combined Los Angeles, Orange County Medical Schools and Hospitals	Los Angeles, Calif
31	Hawaii	University of Hawaii Medical School	Honolulu, Hawaii
32	Puerto Rico	University of Puerto Rico	San Juan, P.R.

Began

'68

'69

Grants
'70

'71

'72

'73

on	DC	Total	DC	Total	DC	Total	DC	Total	DC	Total	DC	Total
California (Irvine) #23 #84			206,100	272,600	206,500	237,700	125,600	175,400	108,388	135,550	110,000	137,400
Colorado/Wyoming #13 #33			58,100	71,000	76,000	91,000	33,800	38,600	40,000	51,211		
Idaho #14			133,600	156,600	170,800	209,400	114,100	143,500	73,333	90,305	33,300	69,200
New Delaware Valley #4/69			188,270	247,500	242,477	319,200	?	161,556	177,063	247,599	147,649	150,000
North Carolina #11			210,900		114,600		82,700	107,000	94,853	121,000	87,285	
North Carolina #11/68			59,600		95,700	121,200	73,700	99,100	66,900	94,424	Contract for \$135,000	
New York Metro #2 #31 A & B			157,500	255,300	141,600	191,100		172,000	Plus NHTS Contract for \$150,000 7/1/72 148,732 213,736	104,337	118,393	
North Rico #3					125,000	137,300	134,135	137,558				
Washington/Alaska #19 #49			54,800	53,400					53,954	75,724		

[illegible]

1 DR. MARGULIES: Thank you, Dr. Burke.

2 I don't believe Dr. Moses is here. He called and
3 indicated he would not be here. He was going to send a tele-
4 gram but I haven't seen it yet. If it arrives I will read it
5 into the record for him.

6 Next, Bob Blum, representing the National Student
7 American Medical Association.

8 MR. BLUM: Mr. Chairman, ladies and gentlemen of
9 the National Advisory Board to the Regional Medical Program,
10 I am here today representing the Student American Medical
11 Association to urge continuation and support for the Regional
12 Medical Programs. My name is Robert Blum; I am a senior
13 medical student at Howard University and am presently the
14 Chairman for SAMA's National Student Health Projects. I speak
15 from the perspective of the health science student and as one
16 who has spent two summers doing community health work with
17 Indian American communities.

18 SAMA wishes to register strong support for con-
19 tinuation and strengthening of the unique nationwide network
20 of 56 Regional Medical Programs. From the viewpoint of the
21 health science student, RMP has represented programs rooted
22 in community concerns with a greater willingness to experiment
23 with new modes of health care delivery and a wider concern in
24 incorporating the various health provider groups into such
25 plans than most any other program in the nation. It has

1 represented a neutral body offering quality programs respected
2 by most health science institutions, yet not restricted by the
3 parochialism of those institutions. And, it has provided
4 opportunities for the development of new educational experiences
5 and patterns of cooperation. It is in this arena where SAMA
6 has worked most closely with the local Regional Medical Program.

7 In Appalachia SAMA has been sending interdis-
8 plinary teams of nursing, dental, medical and pharmacy students
9 for the past five years. These teams work not only under local
10 health providers who act as preceptors but also work with the
11 community on specific public health concerns. A number of
12 Southeastern RMPs have assisted us there. North Carolina,
13 South Carolina and Tennessee Mid-South have provided not only
14 funds, but expertise as well. The end result is to bring
15 increased health services to the region while also stimulating
16 local health manpower.

17 The American Indian Health Project which extends
18 from California to Arizona, New Mexico, Montana and the
19 Dakotas involves communities who have requested student health
20 teams to work on specific projects for the summer months.
21 There again, the local RMP in Arizona has assisted not only
22 with funds and administrative support, but with the generous
23 advice of Drs. Thompson and Melnick.

24 In terms of migrant health, the Oregon RMP
25 supported a student project in its region; support which has

1 led to the establishment of a permanent clinic serving migrants.
2 And the Colorado RMP has funded a student health project which
3 has meant two ongoing clinics and constant student and health
4 professional input in migrant areas of Southern Colorado.

5 As regards premedical and preclinical students,
6 the Student American Medical Association's Medical Education
7 with Community Orientation (MECO) program has placed over a
8 thousand students annually in small community hospitals in
9 almost every state of the union. There, too, local RMPs have
10 been of great support -- specifically, Nebraska, Illinois and
11 North Dakota.

12 And in South Dakota, the Regional Medical Program
13 has supported a health science coalition, which, among other
14 activities, has provided services to area Native American
15 communities.

16 Prior to the Administration's announcement of its
17 planned phase-out of RMP, SAMA had developed with RMPS a pro-
18 posal whereby students throughout the country would establish
19 local planning committees with the 56 RMPs bringing together
20 students, local health providers and consumers, academicians,
21 and various state and county agencies to deal with specific
22 health needs of the area. It represented a mechanism where
23 the experiences of Appalachia, migrant camps and Native
24 American communities could be amplified many fold. And it was
25 the first attempt at an interface between providers and

1 consumers on a state level, where future health professionals
2 would have significant input.

3 There were other plans, too, which had been made.
4 South Carolina RMP expected to support the first year-round
5 project starting in the fall, 1973. And new training programs
6 for interdisciplinary team function were being explored.

7 Presently, all these plans are in question. If
8 the Regional Medical Program is not supported, not only will
9 future health professionals be the losers, but more importantly,
10 those communities which are suffering under the blight of
11 decreasing health services will lose. Over the past two years
12 the Regional Medical Program has served a vital role as a
13 change agent as regards health science students.

14 We, of the Student American Medical Association,
15 urge you to bring this case to Congress and press for con-
16 tinued support for the Regional Medical Program. Since SAMA's
17 charge is in exposing young health professionals to community
18 health needs and to the organization and delivery of health
19 services and since we see a tremendous potential for the
20 Regional Medical Program to play a significant role in this
21 mission, SAMA is prepared to offer testimony before Congress
22 in support of retaining and strengthening the Regional Medical
23 Program.

24 DR. MARGULIES: Thank you, Mr. Blum.

25 I have been asked to read into the record a

1 statement from the American Nurses Association. I will do so.
2 It's not terribly long. It is signed by Eileen Jacobi,
3 Executive Director of the ANA.

4 "The American Nurses' Association would like to have
5 its concerns about the proposed complete cut-off of funds for
6 the Regional Medical Programs brought to the attention of the
7 Advisory Council.

8 "A program of the complexity of RMP which crosses the
9 usual institutional and geographic boundaries for cooperative
10 efforts takes several years to become fully operational. As
11 is expected, there is a variation in the effectiveness of the
12 programs depending on the individual leadership available and
13 the readiness to cooperate that exists in that area at the time.
14 Nursing participation in Regional Medical Programs was often
15 rather minimal in the beginning.

16 "In recent years, however, there has been solid
17 achievement evident in most RMPs. Their continuing education
18 programs have met the needs of many health practitioners. In
19 just the past week we have heard cries of anguish about the
20 budget cuts from nurses in the States of Washington, Wisconsin,
21 District of Columbia, Georgia and New York. These people feel
22 strongly that RMPs are achieving their goals and that patient
23 care is being directly improved through these efforts. The
24 intent of this legislation is to make the advances in health
care made possible through research more readily available to

1 to the average citizen. The need to continue efforts in this
2 direction is still obvious. The planning and coordination
3 efforts of RMPs have also been important contributions.

4 "We speak now to urge reconsideration of the budget
5 decisions relative to closing out Regional Medical Programs.
6 That is not to say that renewal legislation should not be
7 altered to meet changing needs or even that funding levels
8 should be greatly increased. At this time our concern is the
9 proposed closing out of valuable programs while offering no
10 alternative ones to fill the gaps.

11 "The public, as well as health personnel, cannot
12 repeatedly plan on certain services only to find them abruptly
13 cancelled.

14 "We urge the Council to use its good offices to
15 provide reconsideration of this important subject and we are
16 more than willing to provide any assistance we can for that
17 purpose.

18 "It is the position of the American Nurses'
19 Association that high quality health care is a right of every
20 citizen. At this time we think RMPs are making a significant
21 contribution to improving that quality.

22 "I hope this statement can be made a part of the
23 record of your meeting on February 7, 1973, and I regret that I
24 could not personally address you."

25 Dr. Teschan, would you like to speak at this time?

1 DR. TESCHAN: I think all of you can understand what
2 the impact of this development has been on the 56 regions. I
3 think it's important, however, for you to understand that the
4 professionalism of the teams assembled for RMP in the 56 regions
5 are recognizing the necessities that Dr. Margulies is confronted
6 with and we shall comply precisely as required to the require-
7 ments laid on him and upon us.

8 The net effect is that we are having to deliver to
9 the various people with whom we are associated the fact that
10 those expectations which have been raised as a result of the
11 cooperative arrangements laboriously put together are now going
12 to be washed out, and this comes at a time when, as we see it
13 in the country, it's critical that the delivery of health ser-
14 vices be orchestrated with some kind of cooperative partnership
15 between various levels of government and the people who actually
16 deliver most health services, namely, the private institutions
17 and the private providers of health care.

18 Now, when you think about it, there is no other
19 existing mechanism available today for that kind of arrangement
20 to occur. In the counties, in the geography where the action
21 is, when you have as widely regionalized arrangements as the
22 RMPs and as many participants, it follows that like multiple
23 human institutions there will be untidy development. It doesn't
24 proceed in nice, clean, square marching order, however nice
25 that might appear to bureaucratic thinking. But, on the other

1 hand, it has all of the excitement of individual creativity
2 where the action is.

3 So I think that quite aside from even grant support
4 in terms of actually moving money, the thing that is in jeopardy
5 today is the issue of the private providers of health care
6 largely the people who do the health care providing being able
7 to get together and organize a response to community defined
8 needs.

9 Now, that's a fundamental mission which has to be,
10 as we see it in the country, performed some way. It seems to
11 me the alternative then is whether we do it with the existing
12 organization or whether we try to develop some new one. Our
13 feeling is that if RMP -- the RMP coordinators are unanimous
14 in feeling that if the RMP mechanism which exists is phased out,
15 then the chances of developing anything like that in any other
16 way will probably either not occur or will take so long as to
17 be useless.

18 I think the thing that probably has led to most
19 outrage and most upset among coordinators and their staffs is
20 the enormous disparity between the facts as we know them and the
21 language of the FY '74 budget message; that is, the narrative
22 in the budget. Statements made there clearly imply or communi-
23 cate that the authors of that language do not know enough about
24 what goes on in the RMPs to be able to make those statements.

25 So, essentially, we have felt it essential to

1 develop the information which will clearly point out that the
2 allegations made in the budget statements are simply not true.

3 I am delighted to inform you that as a result of a
4 national data project, we have the figures to prove the
5 effectiveness of the expenditure of a half billion dollars in
6 five years. We have the data to prove that patients have been
7 served and that, given the situation of trying to organize
8 individual private enterprises throughout the country, that what
9 has actually happened is really a very creditable record in
10 achieving them. That kind of organization has involved the
11 secondary and specialized care as well as the primary access
12 services and the issues now being addressed of quality assurance
13 and of the continuity and the relationship between these kinds
14 of care.

15 So, essentially, we have got a going concern that
16 is doing the job in the experience of the coordinator group.
17 So, essentially, knowing that, you see, the staffs tend to be
18 very tightly woven and are very coherent at this point. They
19 are remaining together and we are going to proceed together and
20 respond to Dr. Margulies' direction and we are going to remain
21 together as long as possible so that these instruments for doing
22 this job will be available whenever it is finally determined
23 the direction that RMP really should take or what ultimate form
24 it should ultimately have. That kind of talent and capability
25 will be needed in some form.

1 I think the coordinators also will agree that a
2 particular name, a particular means of operating in a changing
3 situation, as a change agent, means that the RMP structure may
4 have to change. That's not a threat. We are not looking at
5 ourselves as a bureaucracy. In the words of Alvin Toffler, we
6 are looking at ourselves as an adhocreaucy; that is, an arrange-
7 ment that changes as the need changes. But the basic mechanism,
8 the basic process, the basic talent must be preserved in some
9 way and this is an extremely valuable instrument which has
10 responded to the administration's interest and directions
11 according to Mr. Nixon's White Paper and in accordance with the
12 administration direction up to now, the programs have responded.
13 As such, they have demonstrated their capability of being a
14 change agent and of responding to new requirements.

15 So it's this capability that I think the coordinators
16 most wish to preserve and I think that's as much as we need to
17 say. Thank you.

18 DR. MARGULIES: Thank you very much, Dr. Teschan.

19 Next on the list I have Dr. Mackintosh, Virginia
20 Academy of Family Physicians.

21 MR. MACKINTOSH: I am Alan Mackintosh and I am
22 President of the Virginia Academy of Family Physicians and Vice
23 President of the county medical society. I'm a practicing
24 physician in Vienna, Virginia, just across the river, in Fairfax
25 County.

1 I am not representing these groups, although each
2 has endorsed RMP in the past. I did not have enough time,
3 frankly, to ask for resolutions pertaining to the continuance
4 of Regional Medical Programs for my separate organizations
5 because I just heard about this meeting yesterday. However, I
6 can speak from experience in that I have been a member of the
7 Regional Advisory Group of VRMP for the past two and a half
8 years and chairman of its review and evaluation committee. I am
9 also a member of the Medical Society of Virginia Liaison
10 Committee to RMP since its inception.

11 As a refugee from the British national health system,
12 I never thought I'd see the day when I would endorse any federal
13 program in the name of health care, but I am pleased with the
14 results in Virginia where all health professionals are being
15 involved. Quality assurance programs are directed into nursing,
16 pharmacy, and dentistry, as well as the medical profession.
17 Private practicing physicians have available systems for self-
18 evaluation to delineate their deficiencies and thereby point
19 out areas in which they can concentrate their continuing
20 education efforts.

21 You might say that doctors can well afford to pay
22 for their own post-graduate education and basically I agree;
23 however, RMP in Virginia have studies ongoing at present speci-
24 fically geared to other less affluent health care providers.
25 For example, coronary care nurses, family nurse practitioners,

1 pharmacists in rural areas, technicians in radiology and
2 laboratory disciplines, medical librarians, dental assistants.
3 Even for M.D.s money may be no object, but finding a nearby
4 course or facility to educate himself or herself is difficult
5 instead of having to leave his practice for days.

6 Virginia Regional Medical Program is bringing the
7 consultant to the periphery. This relieves the consumer of
8 the need to seek temporary care while his provider is off in
9 some medical center having a good time.

10 I am sure there are other methods of achieving the
11 same results, but until RMP began no one coordinated areawide
12 efforts in this area. No one had that obligation. A plethora
13 of programs will always be available in this great nation but
14 the individual provider will be left very much on his or her
15 own to seek out experiences to make him or her a better pro-
16 fessional after the demise of RMP.

17 Lastly, it has taken quite a few years to develop
18 the confidence of health care providers in RMP and I am finally
19 seeing my colleagues lose their natural reticence to accept a
20 federally sponsored program. I do not wish for my testimony to
21 sound like blackmail, but I will be very hesitant to recommend
22 any future federal health care system to my fellow physicians.
23 After all, RMP has only been in existence five or six years and
24 now plans are afoot to phase it out.

1 the continuance of RMP and that this statement be placed in the
2 official record. Thank you.

3 DR. MARGULIES: Thank you, Dr. Mackintosh.

4 Dr. Weinzettel, representing community hospitals.

5 MR. WEINZETTEL: I will correct you, Dr. Margulies.

6 Mr. Weinzettel is not an M.D. I am executive director of the
7 medical center at Savannah, Georgia. I represent the State of
8 Georgia as a delegate to the American Hospital Association where
9 I presented a resolution before the delegates which convened in
10 Washington, D. C. this date.

11 The resolution requests that the Regional Medical
12 Programs be reevaluated to give necessary budget consideration
13 to make RMP viable and on going and I presented it to the House
14 of Delegates yesterday. The entire resolution is available for
15 the record. I will not read the resolution in its entirety in
16 view of the fact that most of you know the advantages of this
17 program to the rural, urban and ghetto areas of this nation.

18 The Georgia Hospital Association, however, has
19 endorsed this program and we also have the endorsement of the
20 American Hospital Association.

21 As an administrator, I would like to speak to the
22 problems that I have to face as an administrator down in Savannah,
23 Georgia. We believe that this program represents the expertise
24 of specialists in the field of health care that can best provide
25 the services required or requested by government -- that is

1 required to be provided as requested by government because this
2 is the only program that I have been familiar with -- and I have
3 been involved in Model Cities programs, in OEO programs and
4 outreach programs of this type where they have had no expertise
5 really to perpetuate their programs in a manner that has been
6 carried on in Georgia, with the development of innovative con-
7 cepts of delivery of health care that this program has fostered,
8 such as area health facilities programs, family planning,
9 publications, health access stations, development of coronary
10 care units tied to medical centers out of small community
11 hospitals, continuing education in small community hospitals to
12 bring the level of education in those hospitals where there has
13 never been an opportunity of educating the nurses and the con-
14 tinuing education of nurses and other paramedical specialists
15 in small hospitals.

16 We have carried on this program as an outreach program
17 of the medical center and 11 small hospitals surrounding the
18 Savannah area where we have specialists who go out in the field
19 and teach in these small hospitals to try to raise the level
20 of education of all personnel within the organization. We feel
21 all this will go down the drain if this program is discontinued.

22 I think the other facet that is so important is we
23 have developed health access stations in rural counties in
24 Georgia where there has been no doctors whatsoever. This has
25 been in cooperation with the Emory University where nurses have

1 been trained to perform the functions of doctors under the
2 guidance of doctors in counties adjoining the counties where
3 there are no physicians. What type of financial support are
4 these counties going to have in the future if these moneys are
5 no longer available from the Federal Government?

6 The action of the President or the Administration
7 with regard to cutting off funds is not consistent with the
8 program itself. As an administrator, I'm going to be faced
9 with additional expense problems in view of the fact that in
10 this year's budget I have budgeted for programs that I am
11 affiliated with with the Regional Medical Program. Obviously,
12 if these funds are cut off, what is my position to explain this
13 to my board of trustees? How do I do this? I have a deficit
14 operation as a result of the RMP pulling out. As I say, it's
15 not consistent with the normalcy of the program in view of the
16 fact that the program normally contains a three-year program
17 of projects whereby you try to develop during that three-year
18 program a financial position which would enable you to fund the
19 project as soon as the federal moneys are withdrawn.

20 The RMP has developed really a seed program of special
21 projects for hospitals and other providers that has a pro-
22 liferating effect because over and above that they provide other
23 projects in which the hospitals become involved. We are being
24 squeezed financially by the Federal Government because we are
25 still under the economic stabilization program and any effect

1 to our budgets as a result of withdrawal of funds of this
2 program will also be an added cost program to hospitals through-
3 out the nation.

4 We urge that this program be continued and assist
5 state planners, medical directors and hospital administrators
6 in developing alternative funding methods. It would be
7 required that we have alternative funding methods if this
8 program is dropped.

9 As I stated earlier, we would like to have the
10 American Hospital Association as well as this organization
11 reevaluate the position relating to RMPs and to give necessary
12 budget consideration to make RMPs viable and ongoing.

13 DR. MARGULIES: Thank you very much.

14 Are there other members of the public who would like
15 to speak to the Council at this time?

16 There is a telegram from Dr. Hurst, Past President
17 of the American Heart Association as follows:

18 "The American Heart Association has followed with
19 great interest the activities of the Division of Regional
20 Medical Programs and is greatly concerned by the zero level of
21 funding proposed in the 1974 presidential budget request. We
22 urge the advisory council to take a strong stand in support of
23 the continuation of those RMP activities that have successfully
24 demonstrated their ability to improve the quality of local and
25 regional medical care."

1 Is there other comment from members of the Council?

2 DR. McPHEDRAN: On this subject?

3 DR. MARGULIES: Yes.

4 DR. McPHEDRAN: Does it have to be entered into the
5 record now or would there be any reason why it couldn't be put
6 off until later on?

7 DR. MARGULIES: It could be. We will have other
8 opportunities.

9 DR. McPHEDRAN: Okay.

10 DR. MARGULIES: Let me just add a little bit to what
11 I discussed with you earlier in the presentation of the phase-
12 out activities, by telling you something of how we are pro-
13 ceeding.

14 Our experience in phasing out the Regional Medical
15 Programs is limited so we have had to devise some techniques
16 for operating it as effectively as possible. We are meeting
17 as a group of key staff people every day so that we can con-
18 sider, in the light of what kind of responses come in through
19 telephone calls and direct visits and so forth, some of the
20 issues which must be addressed. We are trying to establish
21 some kind of grid of action which we could use to advise the
22 coordinators, the regional advisory groups and grantees as they
23 prepare their response to the telegram, and so that we can have
24 some basis for what action we have to take in deciding on the
25 final distribution of funds by April 15.

1 This has led to a further elaboration of some of our
2 concerns with such issues as how we handle contracts versus
3 grants. The issue which several people raised of the poten-
4 tiality for maintaining those areas of competence which RMPs
5 have established over the past several years, so that they can
6 be of value in other structures is an issue of concern to us,
7 as well.

8 To be more specific, where RMPs have proven themselves
9 to have a kind of professional capacity which is multiform in
10 nature and which could be utilized in other kinds of ways,
11 there should be consideration within the states or within
12 regions of ways in which these kinds of skills can be put to
13 their best possible use.

14 As a consequence, we would hope that as the phase-out
15 activities are progressing, there will be consideration by state
16 legislative bodies, departments of health, planning commissions
17 and so forth of the uses to which the experience and skills of
18 RMP staff people might be put. This will be as much as possible
19 a part of the general consideration which we will give to the
20 material which is transmitted to us and the kinds of decisions
21 which we will then have to make based upon those submissions
22 which are due on March 15.

23 This means that there is a fair amount of shifting of
24 detailed decisions from day to day, but I think we are gaining
25 a reasonable level of understanding. This has been interrupted

1 only by the meeting of the Council, which is of great help in
2 these deliberative processes in any case.

3 DR. MCPHEDRAN: Dr. Margulies, maybe I will enter this
4 into the record now.

5 I feel that the Administration's plan to end RMPs
6 is a serious wasteful error and I think that this error is based
7 on ignorance about what the RMPs have achieved. As Dr. Teschan
8 implies, the budget message implies or asserts that RMPs have
9 not met the aims that they should have and the implication is that
10 they should have done so by now. For my own part, considering
11 human frailty and the huge task to be done, I'm surprised
12 at the progress to date.

13 For example, in fostering cooperative arrangements
14 among "health providers," everyone who knows anything about
15 medicine knows how insular physicians are, how jealous they are
16 of their prerogatives and how sure they are that they are right.
17 If the Administration is really serious about its stated wish
18 to improve the quality of medical care in this country,
19 including the prevention of disease through voluntary -- that
20 is, specifically not compulsory -- arrangement, then it will
21 need the active cooperation of doctors and hospitals, medical
22 schools, medical students, in regional organizations.

23 The RMPs are beginning this task which will doubtless
24 take decades, and no other organizations have even made a start
25 on the enterprise.

1 This ought not to be regarded as a political matter.
2 It would be irresponsible to waste the resources we now have by
3 ending the PMPs and I, too, urge that the Administration
4 reconsider its decision to do this.

5 DR. MARGULIES: We will, of course, not only enter
6 these comments in the record, but they will be transmitted, as
7 the records of this meeting are, to the administrator of HSMHA
8 for him to bring to the attention of the department, and you
9 may be assured that there will be full consideration of all of
10 these comments.

11 Well, if there's no further discussion on this
12 subject or if you would like to return to it later during the
13 open session, we may do so. I would like to move to some
14 information for you and then specifically on RMPS. After that,
15 I will provide you with some further data regarding the work
16 we have been doing with the Social Security Administration on
17 dialysis and transplant reimbursement; and after that, bring to
18 your attention the planning of the Urban Health Conference.

19 I think you would be interested in knowing some of
20 the changes which have taken place during the past several
21 months within the Regional Medical Programs. I will go through
22 these very swiftly for you.

23 In the Albany RMP, Dr. Girard Craft has replaced
24 Dr. Woolsey as coordinator. In Iowa, Dr. Charles Caldwell has
25 been the new coordinator since October. In Oklahoma, Mr. Al

1 Donell has been the coordinator since January 1. You may
2 recall that Dr. Groom retired around September of 1972. In the
3 Intermountain RMP, the Regional Advisory Group has nominated
4 Dr. Ward Studt to be the grantee to be the coordinator of that
5 program.

6 There have been some resignations from programs.
7 Metro D.C., Dr. Wentz has resigned; in New York Metro Dr.
8 Brightman has resigned; in South Dakota, Dr. John Lowe has
9 resigned; and in Connecticut Dr. Henry Clark is resigning as
10 of April 30. Indiana has Dr. Beering still acting and in
11 Western Pennsylvania David Reed is going to continue as he has
12 been for the past year to be the coordinator of that RMP.

13 Finally, there is a new grantee arrangement in Texas
14 where there's a nonprofit organization rather than the Univer-
15 sity of Texas system. This was arranged with the backing and
16 cooperation of the University of Texas system and on their
17 part indicated a better way of managing a statewide system
18 which will allow the university to play an active role but which
19 will not run into some of the bureaucratic encumbrances of being
20 in the University of Texas system with the complications which
21 are involved in that rather large kind of a plan.

22 Dr. Hinman, would you like to summarize the letter
23 which has been sent out and the purposes of it? I think we have
24 copies of it for distribution.

1 charged with the implementation of the end stage kidney program
2 under H.R. 1. We have been requested, through the RMPs and
3 through the Comprehensive Health Planning Service and their
4 local CHP agencies, to assist in the identification of facilities
5 to provide this treatment throughout the country.

6 To this end, about two weeks ago a memorandum was
7 sent to the coordinators of the RMPs and the director of the
8 state CHP agencies alerting them to the fact that they would be
9 getting additional informational requests to submit to the
10 Bureau of Health Insurance certifiers in the local regions.
11 Tomorrow and the next day the Social Security Administration is
12 convening an expert committee to give them suggestions and
13 advice concerning some of the criteria that may be applied to
14 facilities, both hospital-based and self-standing limited care
15 facilities, to provide this care.

16 RMP has been asked to participate in this activity
17 and we will do so. After they have decided upon the criteria
18 and the regulations that will be applied, this information plus
19 data that has come to us from the contract we have with the
20 Joint Commission on Accreditation of Hospitals, will be forwarded
21 to individual RMPs to meet with our regional advisory
22 groups and the health planning agencies in the area to then
23 furnish a list to the local Social Security representatives.

24 As you are aware, we have a contract with JCAH to
25 survey hospitals as to the specialized facilities they have.

1 This was in furtherance of the implementation of Section 907.
2 The deadline for this is the SSA has to be operational, at
3 least have the plans out to the people in the field, the forms
4 and certification, around April 1st, because the law becomes
5 effective July 1. So it's a very tight deadline that the RMPs
6 and CHPs are working under.

7 Any questions?

8 (No Response)

9 DR. MARGULIES: Dr. Chandless, would you like to
10 bring the Council up to date on the Urban Health Conference?

11 DR. CHANDLESS: I would indeed. We thought that the
12 Council would like to know of planning that's gone on for an
13 Urban Health Conference. The date for the conference has
14 already been set as May 13 through 16 in Chicago. It will be
15 held on the campus of the University of Chicago at the Center
16 for Continuing Education.

17 Prior to the St. Louis meeting on quality assurance,
18 there was a planning group that met which consisted of six
19 coordinators, members of the staff of RMPS, and members of the
20 planning service of a number of regional medical programs. It
21 is anticipated that the conference will invite or will have
22 some 300 invitees which will consist of the 56 coordinators,
23 the chairmen of the regional advisory groups, members of their
24 planning staffs. There will be a list of special invited
25 guests and participants and speakers.

1 At the St. Louis planning meeting, the agenda for the
2 conference was spelled out and now the planning for the con-
3 ference in May is getting down to very precise terms. At the
4 conference, it is expect to have wide ranging discussions on the
5 issues in urban health and an attempt to find some of the
6 solutions to improving the quality and quantity of health
7 services being made available to those who live under the urban
8 condition. Certainly it is expected to tap the resources and
9 the expertise inherent in the RMPs so that that expertise can
10 be focused along with other expertise at the local, state and
11 federal level to get at some of the solutions and issues in
12 urban health.

13 Each member of this Council will be invited and we
14 will keep you informed by mail as to the details of the con-
15 ference.

16 DR. MARGULIES: Thank you.

17 Are there any questions or any further comments either
18 from the Council or members of the public on the agenda up to
19 the present time?

20 If there are not, this will conclude the open portion
21 of the meeting of the Regional Medical Program. We will have
22 a coffee break and reconvene at 10:15 at which time we will
23 have the closed session for review of applications.

24 (Recess)

CLOSED SESSION

1
2 DR. MARGULIES: I'd like to call the Council into
3 session again. I think we have a couple people missing but we
4 can probably initiate the business in any case.

5 As you know from looking at your agenda books and
6 as you also know from the discussion which we have had up to
7 the present time, we do have 11 programs with applications in
8 to review at this meeting of the Council. However, with the
9 phase-out of Regional Medical Programs, it means that whatever
10 action you take -- and it is necessary that you take some
11 action for us to do this -- we will be providing grant awards
12 which, at best, would be the equivalent of two months out of
13 twelve months of the year that those programs would be
14 receiving awards.

15 In other words, you can take action. The maximum
16 that we could award in any program would be one/sixth of what
17 the Council level of approval is.

18 Now, as a consequence, we are going to propose that
19 rather than go through a detailed review of the individual
20 programs, we take bloc action, if you find that acceptable.
21 Now, if this should prove to be a questionable activity in the
22 light of any subsequent circumstances, we are scheduling another
23 meeting of the Council in June, as you know. At that time, a
24 number of other issues may come up, such as policy decisions
25 affecting ways in which segments of RMP activities can be

1 maintained. There will have been some new analysis of other
2 programmatic activities and of transfers and so forth which we
3 are going to need Council advice on, but if you think it's
4 reasonable, it would be possible for us at this time, rather
5 than go through a detailed review which would lead to the kinds
6 of Council actions which usually take place, we can, if you want
7 to initiate a vote of that kind, simply carry out a bloc action
8 which would be to approve the recommendations of the review
9 committee, in which case we would have authority to expend those
10 limited funds for the remainder of the fiscal year for those
11 programs which are affected.

12 DR. OCHSNER: I so move.

13 MRS. MARS: Second.

14 DR. MARGULIES: It has been moved and seconded for us
15 to take bloc action accepting the recommendations of the
16 National Review Committee for the applications which are sub-
17 mitted for this round of the Council. Is there any further
18 discussion? I will list them for you. They include under
19 triennium, Intermountain and Washington/Alaska; anniversary
20 prior to triennium, Louisiana, Maryland, New York Metro, North
21 Dakota; anniversary within a triennium, Arizona, Connecticut,
22 Iowa, Metro D.C., Tennessee Mid-South.

23 If there's no further discussion, all in favor please
24 say "Aye."

25 ("Ayes")

1 DR. MARGULIES: Opposed?

2 (No response)

3 DR. MARGULIES: Now, we also have an application from
4 the New York-New Jersey Regional Transplant Program, which is
5 an application which came before this Council on a previous
6 occasion and Council deferred action so that some of the issues
7 which were involved in the application could be resolved.

8 Would you like to speak to the status of that 910
9 application, Ed?

10 DR. HINMAN: The critical issues were that there was
11 a question as to whether the institutions listed in the appli-
12 cation actually had agreed to participate or not. In other
13 words, we had two letters withdrawing support which arrived a
14 week before the application. There were also some budgetary
15 issues and the issues of representation on the advisory committee.

16 Staff has worked with the local RMPs and with the
17 applicant and feels that these issues have been appropriately
18 resolved. So staff is recommending that this application be
19 approved. We raise the issue as to whether it would not be more
20 appropriate for the grantee to be the Metro New York RMP rather
21 than the Council of Blood Banks, so our recommendation is that
22 it be approved to the Metro New York RMP as stated in your
23 books.

24 DR. MARGULIES: Is there a motion for approval of
25 this application?

1 DR. OCHSNER: I so move.

2 DR. MARGULIES: It's been moved. Is there a second?

3 MRS. MORGAN: Second.

4 DR. MARGULIES: Any further discussion?

5 DR. MERRILL: Excuse me, Harold, is this the 910
6 application I was supposed to review?

7 DR. MARGULIES: Yes. You were not here, but we took
8 action on the preceeding programs. I think it would be per-
9 fectly appropriate to review this one. The problem is one of
10 phase-out. So what we are doing is acting on the application.
11 I think it deserves some discussion because it may be turned to
12 other sources for its support. So we would appreciate your
13 input at this time on that 910 application.

14 DR. MERRILL: Well, I essentially agree with the
15 final words of what Ed said. I know the operation. I know the
16 people involved. I think it's a little bit of a jungle, but I
17 think they have made considerable efforts to look very hard at
18 some of the problems and to resolve them in the most appropriate
19 way. I think it deserves a try.

20 I would certainly, if it were going to run for a
21 three-year period, want it very, very closely monitored because
22 it's a very mixed bag of people who, frankly, I think may find
23 it a little difficult to get along with each other over the
24 long haul. But I think certainly action taken under these
25 circumstances is appropriate.

1 DR. HINMAN: The acting coordinator, Metro New York,
2 Dr. Aronson, has taken an extremely active interest in this and
3 a strong leadership role. He feels that this may be the one
4 opportunity to get some of the institutions in the metropolitan
5 New York area that have not been in the habit of talking to
6 each other to at least participate, and the way it is being
7 done is that instead of bloc dollars being allocated to any
8 one institution, it would be on the basis of services rendered.
9 So the quality of your work and the quantity of your work is
10 what determines whether you get any money, and he feels that
11 this may be a vehicle to achieve the basic tenets of RMP.

12 DR. MARGULIES: Any further discussion?

13 All in favor say "Aye."

14 ("Ayes")

15 DR. MARGULIES: Opposed?

16 (No response)

17 DR. MARGULIES: Well, that completes the necessary
18 action for this Council. We have acted on the applications.
19 We have acted on the 910 application. Unless there's other
20 business which the Council wishes to bring up at this time,
21 surprisingly enough, this will bring us to a termination. Any
22 other comments, questions or issues?

23 DR. CANNON: I'd like to move that the Council send
24 Vern Wilson a letter expressing appreciation of his interest in
25 RMP during his tenure.

1 DR. OCHSNER: I second that motion.

2 DR. CANNON: I would say, off the record --

3 (Off the record discussion)

4 DR. MARGULIES: We will certainly accept the sense of
5 the Council. We will omit the P.S., and we will write him in
6 the name of the Council.

7 The meeting is adjourned. Thank you very much.

8 (Whereupon, the meeting was adjourned at 10:30 a.m.)

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